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STATE OF MISSOURI
DIVISION OF PROFESSIONAL REGISTRATION

APPLICATION FOR LICENSURE AS AN OCCUPATIONAL THERAPIST/OCCUPATIONAL THERAPY ASSISTANT/LIMITED PERMIT HOLDER

RETURN TO:
MISSOURI BOARD OF OCCUPATIONAL THERAPY
P.O. BOX 1335
3605 MISSOURI BOULEVARD
JEFFERSON CITY, MISSOURI 65102-1335
TELEPHONE (573) 751-0877 ot@pr.mo.gov
TDD (800) 735-2966 http://pr.mo.gov/octherapy.asp

INSTRUCTIONS

- Please read this form and instructions before completing. This form must be typed or printed legibly in black ink.
- Complete this form in its entirety. Failure to complete in its entirety may delay review of your application.
- Enclose the application fee in the form of a check or money order made payable to the Missouri Board of Occupational Therapy.
- Request that the certifying entity send verification of your credentials directly to the Missouri Board of Occupational Therapy. (Copies of certificates or wallet cards issued by the certifying entity are not acceptable.) A verification request form is provided with this application.
- If you are or have been licensed, certified, registered or been granted a permit as an occupational therapist or occupational therapy assistant or similar title by another state, territory of the United States, or province or country, request that verification of your license, registration, certification or permit be submitted by each state, territory, province or country upon the enclosed verification of licensure form. This form must be received directly from the other state(s), territory, country or province in which a license, certification, registration or permit was held.
- Pursuant to §620.127, RSMo, disclosure of your social security number (SSN) is mandatory. The board will not publicly disclose your SSN without your consent, unless such disclosure is permitted by federal or state law. However, state law allows the board to disclose your SSN in connection with any civil, criminal, administrative or arbitral proceeding, in an investigation in anticipation of litigation, pursuant to a court order, and in the performance of a statutory or constitutional duty or power. The board can also disclose your SSN to another government agency (federal, state or local) and to a private person or entity acting on behalf of, or in cooperation with, a state entity. State law requires the board to provide your SSN to child support and tax compliance officials. A citizen of a foreign country applying for licensure with the division shall be required to submit his/her visa or passport identification number in lieu of the SSN.

Return the completed Missouri Jurisprudence Exam with the Application. This is an open book examination.

Please check the box indicating the type of licensure for which you are applying:

☐ **OCCUPATIONAL THERAPIST** $30.00 FEE
☐ **Occupational Therapy Assistant** $10.00 fee
☐ **OCCUPATIONAL THERAPIST LIMITED PERMIT** $10.00
☐ **Occupational Therapy Assistant Limited Permit** $10.00

FOR OFFICE USE ONLY
LICENSE NUMBER
DATE ISSUED
FEE RECEIVED
DATE DEPOSITED
CHECK NUMBER
INITIALS

APPLICANT DATA

FIRST NAME	MIDDLE NAME	LAST NAME	SUFFIX	FORMER/MAIDEN	E-MAIL ADDRESS

RESIDENCE STREET ADDRESS (IF PO, PLEASE PROVIDE A STREET ADDRESS ALSO)	CITY	STATE	ZIP CODE

SOCIAL SECURITY NUMBER	DATE OF BIRTH	RESIDENCE TELEPHONE NUMBER

CURRENT PLACE OF EMPLOYMENT	DATE EMPLOYMENT BEGAN	EMPLOYMENT TELEPHONE NUMBER

EMPLOYMENT ADDRESS	CITY	STATE	ZIP CODE

LIST ALL STATES OF RESIDENCE SINCE THE AGE OF 18

EDUCATION

COLLEGE, UNIVERSITY OR PROFESSIONAL SCHOOL INCLUDING ANY AND ALL POST SECONDARY EDUCATION	CITY/STATE	DATES ATTENDED				DATE OF DEGREE AND CERTIFICATE AWARDED	DEGREE AND MAJOR COURSE OF STUDY
		FROM		TO			
		MON.	YR.	MON.	YR.		

If you have a disability and require accommodations addressed by the Americans with Disabilities Act, please notify this office at the time of application to insure that reasonable accommodations are made for your needs. Notification must be made in writing and mailed to the Missouri Board of Occupational Therapy, P.O. Box 1335, Jefferson City, Missouri 65102. Notification of special needs must be received at least thirty (30) days in advance of any scheduled examination date. The text telephone number for the hearing impaired is (800) 735-2966.

NATIONAL CREDENTIALS

I HOLD THE FOLLOWING CREDENTIALS

☐ OCCUPATIONAL THERAPIST REGISTERED, OTR® CERTIFICATION NUMBER: _____

☐ OCCUPATIONAL THERAPY ASSISTANT, COTA® CERTIFICATION NUMBER: _____

HAVE YOUR CREDENTIALS EVER BEEN DISCIPLINED, SANCTIONED OR REVOKED? IF YES, EXPLAIN IN A SEPARATE STATEMENT	MONTH AND YEAR OF PASSING EXAM
☐ YES ☐ NO	

LICENSURE HISTORY – LIST ALL STATES IN WHICH YOU HAVE EVER HELD LICENSURE AS AN OCCUPATIONAL THERAPIST OR OCCUPATIONAL THERAPY ASSISTANT, USING ADDITIONAL SHEETS IF NECESSARY.

NAME OF STATE	TYPE OF LICENSE	LICENSE NUMBER	LICENSE STATUS
	☐ OT ☐ OTA		
	☐ OT ☐ OTA		
	☐ OT ☐ OTA		
	☐ OT ☐ OTA		

WORK EXPERIENCE – LIST ALL EMPLOYERS IN THE PAST TEN (10) YEARS BEGIN WITH THE MOST RECENT EMPLOYER, USING ADDITIONAL SHEETS IF NECESSARY

A. NAME OF EMPLOYER | ADDRESS OF EMPLOYER

NATURE OF BUSINESS

FROM MON.	FROM YR.	TO MON.	TO YR.	IMMEDIATE SUPERVISOR'S NAME AND TITLE	
				TITLE OF APPLICANT'S POSITION	LENGTH OF EXPERIENCE IN THIS POSITION

B. NAME OF EMPLOYER | ADDRESS OF EMPLOYER

NATURE OF BUSINESS

FROM MON.	FROM YR.	TO MON.	TO YR.	IMMEDIATE SUPERVISOR'S NAME AND TITLE	
				TITLE OF APPLICANT'S POSITION	LENGTH OF EXPERIENCE IN THIS POSITION

C. NAME OF EMPLOYER | ADDRESS OF EMPLOYER

NATURE OF BUSINESS

FROM MON.	FROM YR.	TO MON.	TO YR.	IMMEDIATE SUPERVISOR'S NAME AND TITLE	
				TITLE OF APPLICANT'S POSITION	LENGTH OF EXPERIENCE IN THIS POSITION

D. NAME AND ADDRESS OF EMPLOYER

NATURE OF BUSINESS

FROM MON.	FROM YR.	TO MON.	TO YR.	IMMEDIATE SUPERVISOR'S NAME AND TITLE	
				TITLE OF APPLICANT'S POSITION	LENGTH OF EXPERIENCE IN THIS POSITION

IMPORTANT EXPLANATIONS REQUIRED IN RESPONSE TO THE FOLLOWING QUESTIONS MUST BE ON A SEPARATE SHEET AND SIGNED BY YOU BEFORE A NOTARY PUBLIC AND NOTARIZED.

Please answer the following questions. If any of the questions are answered yes, please provide a separate statement of explanation.	**YES**	**NO**
1. Have you ever been denied a professional license, certification, registration, or permit?.	☐	☐
2. Has your license, certification, registration, or permit ever been disciplined or restricted?	☐	☐
3. Have you ever voluntarily surrendered a professional license, certification, registration, or permit?	☐	☐
4. If you ever held or applied for a professional license, certification, registration, or permit in any state, country or province, has it been or was it ever denied, reprimanded, suspended, restricted, revoked or otherwise disciplined, curtailed or voluntarily surrendered under the threat of investigation of disciplinary action?	☐	☐
5. Have you ever been charged with or convicted of any felony whether or not sentence was imposed or suspended? If yes, explain fully.	☐	☐
6. Have you in the past five (5) years been charged with or convicted of any federal or state drug laws or rules whether or not sentence was imposed or suspended? If yes, explain fully.	☐	☐
7. Are you now, or have you in the past five (5) years been addicted to or used in excess, alcohol or any prescription drugs or illegal chemical substances? If yes, explain fully.	☐	☐
8. Are you now being treated or have you in the past five (5) years been treated through a drug or alcohol rehabilitation program? If yes, explain fully.	☐	☐
9. Have you in the last five (5) years been convicted, adjudged guilty by a court, pled guilty, or nolo contendere to any traffic offense resulting from or related to the use of drugs or alcohol? If yes, explain fully.	☐	☐
10. Have you ever been restricted or disciplined in any way for unethical behavior or unprofessional conduct?	☐	☐
11. Do you have any pending complaints before any regulatory board or agency?	☐	☐

Pursuant to Section 324.010 RSMo:

☐ **CHECK THIS BOX ONLY IF IN ALL OF THE LAST 3 YEARS: YOU WERE NOT A MISSOURI RESIDENT, YOU DID NOT HAVE ANY MISSOURI INCOME, AND YOU ARE NOT SUBJECT TO ANY TYPE OF MISSOURI INCOME TAX.**

False statements are subject to criminal penalties and/or license discipline.

If you have any questions regarding taxes contact the Department of Revenue at 573-751-7200 or e-mail income@dor.mo.gov.

SWORN AFFIDAVIT

I, the below named applicant, being duly sworn, hereby affirm under penalties of perjury that I am the applicant referred to in the preceding application for a license to practice as an occupational therapist, occupational therapy assistant, or limited permit holder in the state of Missouri, and that all statements and enclosures are true and accurate to the best of my knowledge, information and belief.

I submit for consideration this application as required by the Missouri law governing the practice of occupational therapy subject to the rules and regulations of the Missouri Board of Occupational Therapy. I subscribe and agree to abide by all applicable laws and rules regarding the practice of occupational therapy. I hereby certify that I have familiarized myself with sections 324.050 - 324.089 RSMo, known as the Occupational Therapy Practice Act and applicable rules promulgated by the Missouri Board of Occupational Therapy.

Enclosed is the application fee which is not refundable. I understand that the Board may require further information or evidence that it deems reasonable and proper.

Furthermore, I voluntarily consent to a thorough investigation of my present and past employment and other activities for the purpose of verifying my qualifications.

MUST BE SIGNED IN PRESENCE OF NOTARY	SIGNATURE OF APPLICANT ▶	
NOTARY PUBLIC EMBOSSER SEAL OR BLACK INK RUBBER STAMP	STATE OF	COUNTY (OR CITY OF ST. LOUIS)
	SUBSCRIBED AND SWORN BEFORE ME, THIS DAY OF YEAR	**USE RUBBER STAMP IN CLEAR AREA BELOW.**
	NOTARY PUBLIC SIGNATURE / MY COMMISSION EXPIRES	
	NOTARY PUBLIC NAME (TYPED OR PRINTED)	

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PERMIT NUMBER (IF APPLICABLE)	LICENSE NUMBER	
LAST NAME	FIRST NAME	MIDDLE

	ITEM	DATE	FEES & SCORES	PROBLEMS CLARIFIED
	APPLICATION RECEIVED			
	APPLICABLE FEE RECEIVED			
	APPLICATION SIGNED & NOTARIZED			
	VERIFICATION OF NATIONAL CERTIFICATION			
	VERIFICATION OF STATE LICENSURE			
	MISSOURI JURISPRUDENCE EXAM RECEIVED			
	ADDENDUM TO ORIGINAL APPLICATION			
	DATE APPLICATION COMPLETED			
	DATE ORIGINAL LICENSE ISSUED			
LIMITED PERMIT HOLDER				
	FINGERPRINTS			
	VERIFICATION OF ELIGIBILITY TO SET FOR EXAM			
	DATE ORIGINAL PERMIT ISSUED		**EXTENDED THROUGH**	**EXPIRED DATE**
	DATE OF FIRST AVAILABLE EXAMINATION		PASSED SCORE	FAILED SCORE
	DATE RENEWAL PERMIT ISSUED		**VALID THROUGH**	
	DATE OF SECOND AVAILABLE EXAMINATION		PASSED SCORE	FAILED SCORE
	DATE VOIDED PERMIT RECEIVED			
	SENT OT PRACTICE ACT			
	SENT NEWSLETTER			

COMMENTS AND/OR PROBLEMS: